	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155695	B. WING		04/21/2011
	PROVIDER OR SUPPLIER		1400	r address, city, state, zip code W FRANKLIN ST ART, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0000	Complaints IN00 IN00089027. Complaint IN000 Federal/state defiallegations are ciand F514 Complaint IN000 Federal/state defi	088375- Substantiated. iciencies related to the ted at F281, F282, F328 089027-Substantiated. iciencies related to the ed at F281, F282, F322, 18-21/11 003075 : 155695 0364160	F0000	The creation and submission of this plan of correction do not constitute an admission this provider of any concluset forth in the statement of deficiencies, or of any violation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requivalence.	pes n by sion f ation he

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 003075 Page 1 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155695	B. WINC			04/21/20	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	•	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E E	COMPLETION
F0281 SS=D	Sample: 12 Supplemental san These deficiencie findings cited in 16.2. Quality review of 2011 by Bev Fau The services provifacility must meet quality. Based on interview review, th to ensure (LPN # 4) during me administra familiar w medication	es also reflect state accordance with 410 IAC completed on April 26, alkner, RN aded or arranged by the professional standards of observation, and record e facility failed 1 of 7 nurses cobserved edication ation was	F02	281	F 281What corrective action will be accomplished for the residents found to have bee affected by the deficient practice? It is the practice of facility that all services provide or arranged by the facility me professional standards of quarent Resident D: the MAR has bee corrected to include the spec route of administration for the identified medication. This resident experienced no negal outcome as a result of this practice. LPN #4 is not current employed at this facility. How you identify other residents having the potential to be affected the same deficient practice and what corrective action will be taken? All	this ded eet ality. een eific e ative	DATE 05/21/2011

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ĺ		NSTRUCTION 00	(X3) DATE SU COMPLE	
		155695	A. BUI B. WIN	LDING IG		04/21/20	11
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
		•			FRANKLIN ST		
	IDE VILLAGE			L	RT, IN46516		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
	injectable	medication.			residents with orders for injectable medications have	the	
	This deficient practice				potential to be affected by the practice and will be identified	is	
		of 9 residents			through a facility audit. This a will identify all residents with		
		edications were			orders for injectable medicat	ions	
					and ensure that appropriate routes of administration are		
	observed.	Resident D			included and noted on the M The Nurse Management Tea	I .	
					responsible for completion of		
	Findings include:				audit.What measures will be	- 1	
	rindings	iliciude.			into place or what systemic changes you will make to	;	
					ensure that the deficient		
	During th	e observation			practice does not recur?A		
					Nursing In-service is scheduled for 5/10/2011. This In-service		
	of the med	dication pass			be given by Corporate Nurse		
	by I PN #	4, on 4/19/11			Consultants and/or designee include review of the facility		
	~				titled "Injectable Medication	Jolicy	
	at 8:25 a.ı	m., the nurse			Procedure". The In-service w		
	indicated	she was going			also review appropriate route administration for commonly	es of	
		0 0			administered medications. The		
	to give Lo	ovenox 40 mg,			nurses will be instructed that		
	subcutane	ously into			they are ever unsure how to a medication, they should se	~ 1	
		•			guidance from a member of		
	Resident	D's left upper			Nurse Management Team. I addition, the facility will cond		
	arm. Lov	enox is an			Skills Validation Fair on		
					5/10/2011. This Fair will requal nurses to do return	iire	
	anticoagu	iaiit.			demonstrations and compete	ency	
					checks on all basic nursing s	- 1	
	Wilson gradied also 441.				including administration of injectable medications. How	will	
	wnen que	eried about the			the corrective action(s) be		
					monitored to ensure the		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
111,2 12,111	or comment.	155695	A. BUII B. WIN	LDING IG		04/21/2011
	PROVIDER OR SUPPLIER DE VILLAGE		р. үүн	STREET A	DDDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIA' DEFICIENCY)	DATE
TAG	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	deficient practice will not re i.e. what quality assurance program will be put into place? To ensure compliance this corrective action, the DN and/or designee will be responsible for completion of CQI tool titled "Documentation MAR/TAR/Flow Sheet" daily weeks and then weekly there to ensure routes of administrare noted on all MARs. Additionally, Skills Validation competency checks will be completed on all newly hired nurses within the first 60 day employment, all charge nurs during skills validations, as needed, and at least annuall thereafter. Findings will be submitted to the CQI Commi for review and follow up. Compliance Date: 05/21/201	ecur, e with IS f the on x3 eafter eation and s of es
	she had be by the fact than three	she indicated een employed ility "more months." f information in Nursing Drug				

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155695	B. WING		04/21/2011
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 00 W FRANKLIN ST	
RIVERSI	DE VILLAGE			KHART, IN46516	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE DATE
	Handbook	x,page 406, on			
	4/19/11 at	2:00 p.m.,			
	indicated	"Inject drug			
	deep subc	utaneously			
	with patie	nt in supine			
	position.	Alternate left			
	and right a	anterolateral			
	and poster	rolateral			
	abdomina	l wall sites."			
	This feder	al tag relates to			
	Complain	ts IN00088375			
	and IN000	089027.			
	3.1-35(g)((1)			
	(8)	ζ-)			
F0282		ided or arranged by the ovided by qualified persons			
SS=E		n each resident's written			
		observation,	F0282	F 282What corrective actio will be accomplished for the residents found to have be	nose

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155695			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	interviews review, the to follow porders for administrative residents were review medications ample of B, C, F and Findings in tour, on 4, a.m., Residents, and the second residents were review medications ample of the second residents were review medications and the second resident	s and record e facility failed physician's medication ation for 5 of 8 whose records ewed for n accuracy in a 12. Residents ad E			CROSS-REFERENCED TO THE APPROPRIA	f this be as in ent's at B are was on bt acome there ations. iied. ace result the een atome dow dents tye to be will be udit of rders as in ent's at in ent's a	
	oxygen ru face mask	nning via a			accurately transcribed and administered as ordered. Wi measures will be put into p or what systemic changes will make to ensure that the deficient practice does not	hat blace you e	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
111,212,111	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	155695	A. BUIL B. WING			04/21/2011
RIVERSID	ROVIDER OR SUPPLIER DE VILLAGE		D. WIIV	STREET A 1400 W ELKHAI	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	The clinic	al record of			recur? A Nursing In-service to be held on 05/10/2011. This	will
	Resident I	3 was			In-service will be given by Corporate Nurse Consultants	
	reviewed,	on 4/18/11 at			and/or designee. This In-servill include review of the facil	
	5:30 a.m., and indicated				policy titled, "Medication and Treatment Procedure". This In-service will also review	
	she had be	een readmitted				
	to the faci	lity on 4/14/11,			tion .	
	following	hospitalization			tic d.	
	for pneumonia. The				Medication Pass Procedure value of the upcore of the upcor	ming
	orders, dat	ted 4/14/11,			the corrective action(s) be	"
	indicated t	the resident			monitored to ensure the deficient practice will not re	ecur,
	was to hav	ve nebulizer			i.e. what quality assurance program will be put into pla	
	treatments	s of Albuterol			To ensure ongoing compliand with this corrective action, the	e
	2.5 Ipratre	opium 0.5 mg			DNS and/or designee will be responsible for completion of CQI Tool titled, "Medication	
	every four	hours. The			Administration Pass" daily x3 weeks and weekly thereafter	
	order had	been			addition, the DNS and/or designee will conduct randon	
	transcribe	d as every four			unannounced Medication Pa Observations on all newly hir	ss
	hours, but	the times on			nurses within the first 60 day employment and on all curre	s of
	the Medic	ation			nurses as needed and at least annually thereafter. Findings	st
	Administr	ation Record			be submitted to the CQI Committee for review and fol	
	(MAR) wo	ere set for only			up. Compliance Date: 05/21/	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 04/21/2	LETED	
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	four times	a day (9:00					
	a.m., 1:00	p.m., 5:00					
	p.m., and 9:00 p.m.).						
	The two d	oses for 1:00					
	a.m., and	5:00 a.m., had					
	been left o	off the MAR.					
	The reside						
	"missed" 1	the night doses					
	on 4/15, 4	4/16, and					
	4/17/11.	The MAR was					
	corrected	by LPN #5, on					
	4/18/11.						
	2. The cli	nical record of					
	Resident (C was					
	reviewed,	on 4/18/11 at					
	8:30 a.m.,	and indicated					
	the residen	nt was to have					
	Zolpidem	Tartrate 5 mg,					
	each night	t due to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155695		ļ .	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	insomnia.	The physician					
	had ordere	ed the sleeping					
	medicatio	n on 1/6/11.					
	The sign of	out sheet for					
	the sleeping	ng medication					
	had no en	tries of the					
	medication being taken						
	from the medication cart						
	on 3/25 or	3/26/11. The					
	narcotic c	ount had been					
	accurate o	on both days,					
	indicating	the medication					
	had not be	een removed					
	from the c	eart or given.					
	The MAR	was initialed					
	to indicate	e the					
	medicatio	n had been					
	given.						
	During an	interview with					

003075

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MULTIPL A. BUILDING B. WING	E CON	00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		140	0 W F	DRESS, CITY, STATE, ZIP CODE FRANKLIN ST T, IN46516	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	RN #2, or	14/18/11, at					
	9:00 a.m.,	she was					
	unsure wh						
	medicatio	n had not been					
	given as o	ordered the two					
	nights, or	why the MAR					
	had been s						
	indicate the medication						
	had been	given.					
	for Resider reviewed, 9:45 a.m., the resider receiving 0.5 mg (for each even p.m. since	ent E was on 4/18/11 at and indicated int had been clonazepam or anxiety) ing at 5:00 2/18/11. She been receiving					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		A. BUII	LDING	NSTRUCTION 00	1	ETED
ROVIDER OR SUPPLIER DE VILLAGE		p. wiiv	STREET A	FRANKLIN ST	1	
(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
0.25 each	morning at					
9:00 a.m.						
The MAR	for April					
2011, indi	cated the 0.5					
mg dose a	t 5:00 p.m.,					
had been g	given on					
4/17/11, but the						
controlled sign out						
record ind	icated only					
one of the	0.25 mg					
tablets had	d been taken					
from the s	upply. The					
controlled	drug count					
had been a	accurate at the					
end of the	shift,					
indicating	only one					
tablet had	been given,					
rather than	n the two					
needed for	r the 0.5 mg					
dose.						
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OR 0.25 each 9:00 a.m. The MAR 2011, indiving dose a had been a had been a tablets had from the secontrolled had been a end of the indicating tablet had rather than needed for	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0.25 each morning at 9:00 a.m. The MAR for April 2011, indicated the 0.5 mg dose at 5:00 p.m., had been given on 4/17/11, but the controlled sign out record indicated only one of the 0.25 mg tablets had been taken from the supply. The controlled drug count had been accurate at the end of the shift, indicating only one tablet had been given, rather than the two needed for the 0.5 mg	DENTIFICATION NUMBER: 155695 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0.25 each morning at 9:00 a.m. The MAR for April 2011, indicated the 0.5 mg dose at 5:00 p.m., had been given on 4/17/11, but the controlled sign out record indicated only one of the 0.25 mg tablets had been taken from the supply. The controlled drug count had been accurate at the end of the shift, indicating only one tablet had been given, rather than the two needed for the 0.5 mg	DEVILED TO THE PROPERTY OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O.25 each morning at 9:00 a.m. The MAR for April 2011, indicated the 0.5 mg dose at 5:00 p.m., had been given on 4/17/11, but the controlled sign out record indicated only one of the 0.25 mg tablets had been taken from the supply. The controlled drug count had been accurate at the end of the shift, indicating only one tablet had been given, rather than the two needed for the 0.5 mg	SUNMARY STATEMENT OF DEPICIENCIES SUNMARY STATEMENT OF DEPICIENCIES SUNMARY STATEMENT OF DEPICIENCIES SUNMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDERS PLAN OF CORRECTION RECORD OR A PROVIDER	DENTIFICATION NUMBER: 155695 A BUILDING DO COMPL 04/21/2

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		INSTRUCTION 00	(X3) DATE S COMPL	
		155695	B. WIN	G		04/21/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST		
RIVERSI	DE VILLAGE			1	RT, IN46516		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	OULD BE COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	4. The cli	nical record of					
	Resident F was						
	reviewed,	on 4/18/11 at					
	11:30 a.m	., and indicated					
	the physic						
	ordered clonazepam 0.5						
	mg twice	daily on					
	3/1/11. T	he dosage of					
	the medica	ation for the					
	9:00 p.m.,	dose on the					
	MAR for A	April 2011,					
	had been 1	marked over					
	and the en	try had been					
	changed to	o indicate two					
	tablets sho	ould be given					
	for the 0.5	mg dose. The					
	medication	n was 0.5 mg					
	in the cart	and had been					
	dispensed	that way. The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MU: A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER			1400 W	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	resident h	ad received					
	twice the	ordered dose					
	on 4/17/11	1 at 9:00 p.m.					
	Two table	ts had been					
	signed out	t and indicated					
	on the cor	ntrolled drug					
	log.						
	During an	interview with					
	LPN#3, or	n 4/18/11 at					
	12:00 noo	n, she					
	indicated	the pharmacy					
	had previous	ously sent					
	tablets of	0.25 mg					
	strength a	nd one of the					
	nurses mu	st have					
	thought tv	vo tablets were					
	needed for	r the 0.5 mg					
	dosage, no	ot realizing the					
		re 0.5 mg each.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2011			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		ral tag relates to ts IN00088375 089027.						
	3.1-35(g)((2)						
F0222	Paced on the com	probancive accessment of						
F0322 SS=D	a resident, the factoresident who is fer gastrostomy tube treatment and ser pneumonia, diarrh metabolic abnorm nasal-pharyngeal possible, normal e	ulcers and to restore, if eating skills.	F0322	F 322 What corrective actic	on(s) 05/21/2011			
	Based on	observation,	FU322	will be accomplished for th				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE S COMPL 04/21/2	ETED	
	PROVIDER OR SUPPLIER		_	1400 W	ADDRESS, CITY, STATE, ZIP CODE 7 FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	interviews review, the to ensure receiving feedings is 12 was posappropriate prevention during feed D. Findings is 1. During the gastros (g-tube) feedings is 1. Resident I	and record e facility failed l of 5 residents enteral n a sample of esitioned tely for n of aspiration eding. Resident stomy tube			CROSS-REFERENCED TO THE APPROPRIA	en f this by tube event rated trome PN #4 this by d be be de to be deiving d of lace you e will by	
		Director of			and/or designee. This In-Ser will include review of the fac policy tilted, "Enteral Therap Resident Care". The staff wi re-educated on proper techr		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CON	(X3) DATE SURVEY COMPLETED		
		155695	A. BUILI B. WING		00	04/21/2011
	PROVIDER OR SUPPLIER			STREET AL	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST IT, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	present, th	ne resident was			regarding checking for place and residual as well as prope	er
	flat in bed	with no			positioning of the bed during after enteral feedings. How v	• • • • • • • • • • • • • • • • • • •
	elevation	of the head of			the corrective action(s) be monitored to ensure the	
	the bed. 7	The g-tube			deficient practice will not re i.e. what quality assurance	
	feeding of	Elevity 1.0 was			program will be put into pla To ensure ongoing compliand	ce
	running co	ontinuously at			with this corrective action, the DNS and/or designee will be	
	75 cc per	hour.			responsible for completion of CQI Audit Tool tilted, "Entera	ı
					Therapy" monthly x3 months then quarterly thereafter.	
	Review of	f physician's			Additionally, Skills Validation competency checks will be	
	orders, up	on admission			completed on all newly hired nurses within the first 60 day	's of
	on 4/15/11	l, indicated the			employment, as needed and least annually thereafter. Find will be submitted to the CQI	
	head of th	e bed was to			Committee for review and fol up. The Maintenance Director	· I
	be elevate	d 30-45			complete weekly inspections document in the Preventive	
	degrees.				Maintenance Log on all beds residents receiving naso-gas	
					or gastrostomy feedings to ensure elevation equipment i	
	During an	interview with			place and functional. The Maintenance Director will be	
	the ADoN	on 4/19/11,			notified to install elevation equipment on beds for new	
	during the	observation,			admissions or when new ord are received for naso-gastric	
	she indica	ted the head of			gastrostomy feedings. To en ongoing compliance with this	nsure
	the bed sh	ould have been			corrective action, the Maintenance Director and/or	
					designee will be responsible	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155695		LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER DE VILLAGE		1400 W	ADDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	elevated and immediately raised it to		completion of the CQ titled, "Environmental		Safety –	
				Resident Area" weekly x4 w and then monthly thereafter	-	
	30 degree	s. The resident		Compliance Date: 05/21/20	11	
	did not ap	pear to have				
	any troubl	le with				
	breathing	at the time.				
	Review of	f the facility				
	policy for	g-tube care,				
	dated 3/10	and provided				
	by the AD	oN, on 4/18/11				
	at 10:00 a	.m., indicated				
	"Head of	bed is to be				
	elevated a	t a 30-45				
	degree an	gle during				
	feeding ar	nd for at least				
	one (1) ho	our after				
	, í	completed to				
	_	astric reflux				
	_	ole aspiration."				
	1	1				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		LDING	NSTRUCTION 00	(X3) DATE COMPI 04/21/2	LETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	2. During observation administration gastroston (g-tube), of 8:40 a.m., observed	g the on of the ation of ns via a				
	D's g-tube stethoscop failed to c placement auscultation aspirate for finding no administer	e. She had no be with her and heck the t by on. She did or residual and one, red the ns by first				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695		(X2) MULTIPLE CC A. BUILDING B. WING	00	i .	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		1400 W	ADDRESS, CITY, STATE, ZIP CO I FRANKLIN ST RT, IN46516	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	before and	d after the				
	medicatio	ns.				
	feeding vaprocedure 3/10/11, a LPN #4, o validation was able to the placer by auscult aspiration. This feder	e, dated and signed by on 3/10/11, the indicated she to demonstrate ment of a g-tube tation and				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155695		B. WING 04/21/			011
	PROVIDER OR SUPPLIER		!	1400 W	DDRESS, CITY, STATE, ZIP CODE FRANKLIN ST RT, IN46516		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0328 SS=D	proper treatment a special services: Injections; Parenteral and en Colostomy, uretera Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and Prostheses.	ostomy, or ileostomy care; e; g;		220	E 220 M/bat compative action	05/21/2011	
		observation,	FU	328	F 328 What corrective actio will be accomplished for the residents found to have been sometimes.	ose	05/21/2011
		affected by the deficient					
	review, th	e facility failed	provider	· ·	vider to ensure that residents		
	to ensure	an injection of			receive proper treatment and care for special services.		
	blood thin	nning		sub	Resident D continues to rece subcutaneous injections per	eive	
	medicatio	n was			manufacturer's recommendations. This residual		
	administer	red properly to			experienced no negative out	N #4	
	1 of 1 resi	dents receiving			is no longer employed by the facility. How will you identif		
	the blood	thinner			other residents having the potential to be affected the		
	Lovenox i	in a sample of			same deficient practice and what corrective action will be	ре	
	12. Resid	ent D			taken? Any residents with or for injectable medications ha	ve	
	Findings i			the potential to be affected by this practice and will be identified through a facility audit. This audit will indentify all residents will order for injectable medications and ensure that appropriate routes of administration are		audit	
	During the	e observation			included and noted on the Ma	AR.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
	or continue non	155695	A. BUI B. WIN	LDING		04/21/2011
	PROVIDER OR SUPPLIER DE VILLAGE		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE / FRANKLIN ST RT, IN46516	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	of the med	dication pass			The Nurse Management Tea responsible for completion or	
	by LPN #4	4, on 4/19/11			audit. What measures will b put into place or what syste	
	at 8:25 a.r.	n., the nurse			changes you will make to ensure that the deficient	
	indicated s	she was going			practice does not recur? A Nursing In-service is schedu	led
	to give Lo	venox 40 mg,			for 5/10/2011. This In-service be conducted by Corporate I	Nurse
	subcutane	ously into			Consultants and/or designee This In-service will include re	
	Resident I	O's left upper			of the facility policy titled "Injectable Medication	
	arm. Love	enox is an			Procedure". The In-service w also review appropriate route	es of
	anticoagul	lant.			administration for commonly administered medications. T nurses will be instructed that	he
	medication	ried about the n and where oing to inject			they are ever unsure how to a medication, they should se guidance from a member of Nurse Management Team. I addition, the facility will cond Skills Validation Fair on 5/10/2011. This Fair will requall nurses to do return	ek the n uct a
	it, LPN #4	indicated she			demonstrations and compete checks on all basic nursing s	•
	had never	given the			including administration of injectable medications. How	
	medication	n before and			the corrective action(s) be monitored to ensure the	
	was unfan	niliar with it.			deficient practice will not re	ecur,
	She summ	noned the unit			program will be put into pla To ensure compliance with the	
	director w	ho informed			corrective action, the DNS or designee will be responsible	r
	her it shou	ıld be given			completion of the CQI tool tit "Documentation MAR/TAR/F	led,

003075

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	ETED	
		155695	B. WIN			T 04/21/2011	
NAME OF F	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
חויירם כו	DEVILLAGE				FRANKLIN ST		
	DE VILLAGE				RT, IN46516		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	During an LPN #4, of 8:50 a.m., she had be by the fact than three. Review of the 2010 Mandbook 4/19/11 at indicated deep subcowith patie position. and right a and poster.	domen. Interview with on 4/19/11 at she indicated een employed ility "more months." Information in Nursing Drug (2:00 p.m., "Inject drug utaneously in supine Alternate left anterolateral			CROSS-REFERENCED TO THE APPROPRIAT	lly, tency all e first all at dings	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695			(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2011			
	PROVIDER OR SUPPLIER DE VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
		(1)						
F0514 SS=D	each resident in a professional stand complete; accurat accessible; and sy The clinical record information to ider the resident's asseand services provipreadmission screetstate; and progressional state;	record review,	F0514	F 514 What corrective action will be accomplished for the residents found to have been affected by the deficient practice? It is the practice of	ose en			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155695 A. BUILDING B. WING 00 COMPLET 04/21/201	
B. WING	
CERTIFIES A DEPEND OF THE CONTROL OF	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST	
RIVERSIDE VILLAGE ELKHART, IN46516	
	07.5
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
provider to ensure clinical records	
ensure complete and are complete and are complete and accurately	
accurate records were documented. Resident C is receiving her medications as	
ordered. This resident	
maintained related to the experienced no negative outcome	
documentation of as a result of this finding. How will you identify other residents	
will you identify other residents having the potential to be	
medications for 1	
practice and what corrective	
resident in a sample of action will be taken? All	
12, whose records were residents are at risk to be affected by this finding. All	
resident's charts will be audited to	
reviewed for accuracy.	
Resident C administered per physician's order and documented	
order and documented accordingly in the clinical record.	
What measures will be put into	
place or what systemic	
Findings include: changes you will make to	
ensure that the deficient practice does not recur? A	
Nursing In-service will be held on	
The clinical record of 05/10/2011. This In-service will be	
Resident C was conducted by Corporate Nurse Consultants and/or designee.	
This In-service will include review	
reviewed, on $4/18/11$ at of the facility policy tilted,	
"General Guidelines for	
8:30 a.m. and indicated Administering Medication". This In-service will also review	
the resident had been documentation guidelines during	
medication administration. How	
admitted to the facility will the corrective action(s) be monitored to ensure the	
on 1/4/11. Her deficient practice will not recur,	
i.e. what quality assurance	
d1agnoses included, but program will be put into place?	
The DNS and/or designee will be	

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2011		
NAME OF PROVIDER OR SUPPLIER RIVERSIDE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	were not limited to: hypertension, mild dementia, constipation and depression. Review of the current MAR, for April 2011, indicated the medications amodipine besylate 5 mg, (for hypertension) and bystolic 5 mg (also for hypertension) had not been signed as given on 4/14 or 4/15/11 at 1:00			responsible for completion CQI Tool titled, "Document MAR/TAR/Flow Sheet" dai		ation		
					weeks and then weekly there to ensure ongoing compliance		after	
					Any findings will be submitted the CQI Committee for review	ew		
					and follow up. Compliance I 05/21/2011	Jate:		
		rdered. The						
	MAR was	also blank for						
	doses of C	Cymbalta 30						
	l C	epression) and						
		0 mg (a stool						
	softener) (on 4/15 at 8:00						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	NT OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155695	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM 04/21	E SURVEY PLETED /2011			
	PROVIDER OR SUPPLIE	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 W FRANKLIN ST ELKHART, IN46516						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)		SHOULD BE	ULD BE COMPLETION			
	a.m.								
		ral tag relates to its IN00088375							
	3.1-50(a)(3.1-50(a)(